

30 days after determining that the information required by this subpart has been received.

(b) *Extension at the discretion of the Secretary.* The Secretary may, in her discretion, extend the 30 day time period in paragraph (a) of this section for as long a time as necessary not to exceed 30 days.

§ 158.346 Request for reconsideration.

(a) *Requesting reconsideration.* A State whose request for adjustment to the MLR standard has been denied by the Secretary may request reconsideration of that determination. A request for reconsideration must be submitted in writing to the Secretary within 10 days of her decision to deny the State's request for an adjustment, and may include any additional information in support of its request.

(b) *Reconsideration determination.* The Secretary will issue her determination on a State's request for reconsideration within 20 days of receiving the reconsideration request.

§ 158.350 Subsequent requests for adjustment to the medical loss ratio.

A State that has made a previous request for an adjustment to the MLR standard must, in addition to the other information required by this subpart, submit information as to what steps the State has taken since its initial and other prior requests, if any, to increase the likelihood that enrollees who have health coverage through issuers that are considered likely to exit the State's individual market will receive coverage at a comparable price and with comparable benefits if the issuer does exit the market.

Subpart D—HHS Enforcement

§ 158.401 HHS enforcement.

HHS enforces the reporting and rebate requirements described in subparts A and B, including but not limited to:

(a) The requirement that such reports be submitted timely.

(b) The requirement that the data reported complies with the definitions and criteria set forth in this part.

(c) The requirement that rebates be paid timely and accurately.

§ 158.402 Audits.

(a) *Notice of Audit.* HHS will provide 30 days advance notice of its intent to conduct an audit of an issuer.

(b) *Conferences.* All audits will include an entrance conference at which the scope of the audit will be presented and an exit conference at which the initial audit findings will be discussed.

(c) *Preliminary Audit Findings.* HHS will share its preliminary audit findings with the issuer, which will then have 30 days to respond to such findings. HHS may extend, for good cause, the time for an issuer to submit such a response.

(d) *Final Audit Findings.* If the issuer does not dispute the preliminary findings, the audit findings will become final. Alternatively, if the issuer responds to the preliminary findings, HHS will review and consider such response and finalize the audit findings.

(e) *Corrective actions.* HHS will send a copy of the final audit findings to the issuer as well as any corrective actions that issuer must undertake as a result of the audit findings.

(f) *Order to pay rebates.* If HHS determines as the result of an audit that an issuer has failed to pay rebates it is obligated to pay pursuant to this part, it may order the issuer to pay those rebates, together with interest from the date the rebates were due, in accordance with § 158.240(d) of this part.

§ 158.403 Circumstances in which a State is conducting audits of issuers.

(a) If a State conducts an audit of an issuer's MLR reporting and rebate obligations, HHS may, in the exercise of its discretion, accept the findings of that audit if HHS determines the following:

(1) The laws of the State permit public release of the findings of audits of issuers;

(2) The State's audit reports on the validity of the data regarding expenses and premiums that the issuer reported to the Secretary, including the appropriateness of the allocations of expenses used in such reporting and whether the activities associated with the issuer's reported expenditures for quality improving activities meet the definition of such activities;